Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-11-0483-01

MFDR Date Received
OCTOBER 14, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed please find two copies of a Medical Fee Dispute Resolution Requestor Form DWC-060, along with copies of receipts that have been paid by [injured worker]. We have itemized to the best of our knowledge the reimbursement being sought from the State Office of Risk Management. Please also find a copy of a Judgment dated July 12, 2010 wherein a jury found that [injured worker] has sustained a compensable injury on October 13, 2006. To date we have not received any EOBs from the State Office of Risk Management."

Amount in Dispute: $15,812.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor [injured worker], the Office is unable to determine what providers the claimant had reimbursed. The Office upon receipt of the MCCH decision had all bills that had been received and denied for entitlement audited to pay in accordance with the MCCH decision to include interest. Included with this response is the EOB's and payment summary as proof of the reimbursements.

In Review of the Table of disputed services, the Office is unable to match bills in our system to their reimbursement request as outlined on the DWC 60 table of disputed services to determine if the provider submitted a bill to the carrier for review. The Office requests the claimant communicate with the providers that had performed services during the time frame of 10/20/2006-2/24/2010 and have the provider's refund the amounts paid to the injured worker and submit a bill to SORM on the correct forms as prescribed by the Division for a full review and audit."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2006 through August 31, 2010	Out-of-Pocket Expenses	$15,812.06	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Neither party submitted EOBs.
   - The State Office of Risk Management submitted a payment screen showing payment was made to the injured worker on November 5, 2010 in the amount of $4,465.47 for dates of service October 20, 2006 through July 14, 2010; however, EOBs were not presented to the Division with their response.

Issues

1. Did the requestor's attorney submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307(c)(1)(B)(i)?
2. Is the requestor entitled to reimbursement?

Findings

1. According to 28 Texas Administrative Code §133.307(c)(1)(B)(i) requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. (1) A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (B)A request may be filed later than one year after the date(s) of service if:(i)a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability. Review of the information submitted by the requestor shows the copy of the Agreed Final Judgment is dated July 12, 2010; therefore, the requestor has not met the requirements of the rule. As a result, Medical Fee Dispute Resolution cannot review the merits of the dispute.
2. Review of the submitted documentation finds that the requestor has not meet the requirements of 28 Texas Administrative Code §133.307(c)(1)(B)(i). As a result the amount ordered is $0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 27, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.